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# Groundwork and Rationale

A sea change has occurred in clinical training and supervision, reflecting a new era of accountability. As in other health care professions, such as medicine, it is no longer sufficient in clinical and counseling psychology to assume that competence is routinely attained through the accumulation of academic and training experiences. This emerging "culture of competence" (Roberts, Borden, Christiansen, & Lopez, 2005) requires the demonstration of specific competencies that are used in clinical practice (Falender & Shafranske, 2012b). *Competency-based clinical supervision* orients the supervisor and supervisee to the task of developing professional competence by providing structures and processes designed to achieve this training objective. This volume presents a practical guide to implementing the approach and is intended for both novice and experienced supervisors who are seeking to enhance the effectiveness of their supervision practice. We begin with a brief introduction to clinical supervision.

http://dx.doi.org/10.1037/15962-001
*Supervision Essentials for the Practice of Competency-Based Supervision*, by C. A. Falender and E. P. Shafranske

## RESPONSIBILITIES AND FUNCTIONS OF CLINICAL SUPERVISION

Clinical supervision is the cornerstone of graduate education and clinical training in which a student of psychology gradually develops clinical competence and prepares to become a health service provider as a licensed psychologist (Falender & Shafranske, 2004). In addition to honing clinical skills, supervisees are assimilated into the profession, internalizing its principles, ethics, and values, establishing a foundation for lifelong practice. Although training is a major focus, the supervisor's first responsibility is always to the welfare of the client or patient.[1] The tasks of ensuring patient welfare and facilitating professional development, although distinct responsibilities, are inextricably interrelated. Given their multiple obligations to patients, supervisees, and the profession, supervisors must develop a clear understanding of clinical supervision and incorporate best practices to ensure competence and effectiveness.

## DEFINING CLINICAL SUPERVISION

What precisely is clinical supervision? Definitions abound, reflecting differences in comprehensiveness and emphasis (Bernard & Goodyear, 2014; Falender & Shafranske, 2004; Milne, 2014), which may account for much of the variety of experiences supervisees have during their course of clinical training. We define *clinical supervision* as

> a distinct professional practice that requires balancing the inherent power differential within a collaborative relationship while utilizing both facilitative and evaluative components. It has the multiple goals of monitoring the quality of services provided to clients; protecting the public and gatekeeping for the profession; and enhancing the professional competence and professionalism of the supervisee,

[1] We are mindful that the use of the terms *patient* or *client* to refer to consumers of psychological services reflects theoretical, historical, and contextual background. In this volume, we use *client* and *patient* interchangeably, given the variety of clinical cultures in which supervision is offered and in which this volume is intended for use.

> including developing skill in the use of science-informed assessment procedures, empirically-supported treatments and evidence-based practices. Clinical supervision is experiential, and involves observation, evaluation, feedback, facilitation of supervisee self-reflection and self-assessment, use of didactic and experiential learning approaches, and is conducted in a manner sensitive to individual differences and multicultural context and in which ethical standards, legal prescriptions, and professional practices are used to promote integrity and welfare of the client and communities. (based on Falender & Shafranske, 2004)

This definition is consistent with the *Guidelines for Clinical Supervision in Health Service Psychology*, recently adopted by the American Psychological Association (APA; 2014, 2015), which now serves as policy and defines and directs the practice of clinical supervision:

> Supervision is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. (APA, 2014, p. 5)

Attention to the aims of supervision, as articulated in this definition, and implementation of the associated guidelines to achieve these objectives require a values-based commitment to the highest standards of the profession, in addition to specific knowledge, skills, and attitudes required to competently conduct supervision. Competency-based clinical supervision provides a comprehensive, systematic, and metatheoretical approach to implementing the *Guidelines* that can be applied to all clinical specialties and theoretical orientations. Given its explicit orientation to competency assessment and development, it is uniquely suited to achieve the heightened requirements of accountability within education and clinical training in health service psychology.

## ADVANCING THE NEW ERA OF COMPETENCY-BASED CLINICAL SUPERVISION

Most psychologists believe they are competent to supervise because they have been supervised and, thus, by indirect modeling, know how to supervise. This notion seems widely held, given that most supervisors describe their own personal experience as a supervisee as having the largest influence on their current supervision practice (Genuchi, Rings, Germek, & Cornish, 2015; Rings, Genuchi, Hall, Angelo, & Cornish, 2009). This presumption, that competence to perform supervision is sufficiently established without formal training ignores the complexity of the supervisory process and, further, may lead to the perpetuation of inadequate or poor practices, resulting in marginally effective or even substantially ineffective supervision. These concerns are quite real given the growing awareness that many supervisees have experienced inadequate, lousy (Magnuson, Wilcoxon, & Norem, 2000), harmful (Ellis et al., 2014), or failed supervision (Ladany, 2014). Conducting supervision solely on the basis of past experiences as a consumer of supervision (or efforts to do the opposite of the supervision received) does not furnish an adequate basis for practice. Now acknowledged as a distinct professional practice, clinical supervision requires competence in its performance—competence that is obtained not through osmosis but through specific education and training. As in other professional activities, competence in supervision practice involves evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006) that draws on sound theory, uses empirically supported procedures, considers supervisor and supervisee expertise, and is sensitive to culture and context.

It is ironic that a function so central to the development of clinical competence has been so neglected as a competence itself. It is equally surprising (if not disturbing) that clinical supervision, in contrast to other professional services (e.g., psychological assessment, psychotherapy), has not required specific graduate education and training for its performance. The Association of State and Provincial Psychology Boards (ASPPB) Task Force on Supervision (ASPPB, 2003) expressed similar concern at the lack of training and clarity for such, given the critical role of supervision in the

protection of the public, and recently provided revised regulatory guidelines for training, practice, and conduct in supervision (ASPPB, 2015). Although this volume does not directly address regulatory issues, it does provide a framework for the conduct of clinical supervision that is in keeping with standards and guidelines.

## What We Mean by Competence

A starting point to consider: What do we mean when we ascribe competence to a supervisor? Reflect for a moment on a supervisor you consider to be highly competent. What stands out? Each of us has notions about competence (and often can identify when it is lacking), but what criteria or standards should we use as psychologists and supervisors to orient professional development? *Competence* is generally understood to mean that one is qualified and capable of performing a specific professional function in an effective manner (Kaslow, 2004). This is a good starting point, but competence actually involves more than the performance of specific technical tasks. Rather, it includes many abilities, such as the translation of knowledge into practice, critical judgment, interpersonal skills, metacompetence, and ethical conduct, to name a few. A widely accepted definition, drawn from medicine, describes competence to be "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served" (Epstein & Hundert, 2002, p. 226). Epstein and Hundert (2002) go on to explain that competence builds on a foundation of basic clinical skills and scientific knowledge as well as moral development.

Competence, viewed from this comprehensive perspective, reveals the complex assemblage of knowledge, skills, attitudes, values, and ethics required in health service psychology that is the subject of clinical training and supervision. On the one hand, supervision must include broad foundational competencies, such as attention to relationship or self-assessment, whereas on the other hand, it simultaneously focuses on functional competencies, such as skills in conducting psychological assessment

or treatment interventions, which are specific to the training objectives (Rodolfa et al., 2005).

Practically speaking, competence refers to a state of sufficiency relative to specific performance or training requirements within a given health care or training setting (Falender & Shafranske, 2004). Therefore, competence is not absolute nor an endpoint; it is always relative to the demands of the setting or context. Different health care settings (just as different patients or clients) require different competencies, and at times levels of ability, for treatment or supervision to be effective.

It is important to keep in mind (and to model to supervisees) that competence is constantly evolving and developing, such that practicing clinicians or supervisors never achieve absolute competence. For example, in our view, attaining licensure or board certification should never be considered a final destination; rather, it is one point along the way in a career, in which one strives for excellence, pushing competence forward to meet ever-changing clinical demands. Kaslow (personal communication, June 30, 2014) and other leaders in education and training now bemoan the use of the label, *competency movement* because for many the term implies that there is an endpoint to be achieved—a point at which one will be vested (for all time) as competent. The reality is that our own competence is fleeting because the field continuously advances knowledge and professional practices. It is also the case that we may face our own personal limitations as psychologists over the course of our careers. However, one benchmark of competence to which we all can aspire is the use of metacompetence, or reflection on what we do not know, which involves the ongoing self-assessment of capabilities and limitations, invites feedback from supervisors and trusted colleagues, and spurs us on to maintain and enhance competence. Clinical supervision is fertile ground for such an orientation to competence as a professional responsibility to take root.

## An Intentional Framework

Competency-based clinical supervision aims to transform the training approach from reliance on assumptions of competence to demonstrations

of competence. Although it is reasonable to expect that a supervisee will develop over a course of training, such an assumption is insufficient to establish competence. Similarly, whereas a supervisor may be well intentioned or talented as a clinician, such qualities do not guarantee competence as a supervisor. Measurable outcomes of clinical effectiveness and supervisory effectiveness are required to demonstrate competence. This involves commitment to carefully identify and assess the knowledge, skills, and attitudes that are assembled to form specific competencies. Rather than conducting global appraisals (or forming impressions) of competence, attention is directed to describe and evaluate the supervisee's (or supervisor's) specific use of knowledge, skills, and attitudes in observable behavioral terms. Implementation of this approach requires commitment and intention on the part of the supervisor (as well as the supervisee) because obtaining direct observations of discrete behavior requires not only focused attention but also the ability to assess accurately how each aspect is being used in the performance of the professional activity. A laissez-faire attitude, or even a well-intentioned but passive stance, toward clinical supervision will not suffice. Rather, an active, intentional, and engaged collaboration with the supervisee is required to carefully identify strengths and areas for development, provide feedback, and facilitate learning activities that enhance competence and instill professionalism. Adopting such a proactive stance encourages a vibrant and effective supervisory experience and provides a level of supervisory engagement ensuring client welfare.

## COMPETENCY-BASED CLINICAL SUPERVISION

Competency-based clinical supervision (Falender & Shafranske, 2004, 2007) was developed to enhance the quality and effectiveness of supervision by providing a systematic and comprehensive approach to assess and develop specific clinical and supervision competencies and to perform the interrelated functions of observation, evaluation, feedback, and gatekeeping. The model is unique in its deliberative focus on the constituents of a specific competence as expressed in observable behavior and its focus on

competence throughout the supervision and clinical training process. Competency-based clinical supervision is

> a metatheoretical approach that explicitly identifies the knowledge, skills, and attitudes and values that comprise clinical competencies, informs learning strategies and evaluation procedures, and meets criterion-referenced competence standards, consistent with evidence-based practices, regulations, and the local clinical setting. (APA, 2014, p. 5)

Competency-based clinical supervision is a meta- or transtheoretical approach that ensures accountability and is systematic in its orientation to the multiple competencies that comprise the art and science of supervision (e.g., Farber & Kaslow, 2010) and the development of clinical competence. It can be used in all forms of clinical training (e.g., psychotherapy, neuropsychology, assessment, behavioral health, school) and is suitable for use with a variety of psychotherapy orientations (Gonsalvez & Calvert, 2014), such as cognitive behavior therapy supervision. (Prototypes for transforming theory-based models to competency-based are available in a special issue of *Psychotherapy: Theory, Research, Practice, Training*, Volume 47, 2010, describing psychodynamic, cognitive behavior, humanistic–existential, systemic, and integrative theories.) Competency-based clinical supervision offers a systematic approach that readily accommodates the theoretical and artful aspects of the supervisor's unique skills and clinical orientation.

When we say *criterion-referenced* standards in the definition we gave earlier, we are referring to competencies that have been consensually agreed on by our profession, such as competency benchmarks (Fouad et al., 2009; Hatcher et al., 2013), the identification of the constituents of a competency through disassembling the competence into definable and potentially measurable units (i.e., specific knowledge, skills and attitudes, helps the supervisor and supervisee tailor methods of evaluation and training to the competency; Falender & Shafranske, 2004). Competencies are elements or components of competence, discrete knowledge, skills, and attitudes that comprise competence (Kaslow, 2004). Benchmarks are levels of competence consensually agreed to be appropriate for the developing stages of professional education and training in psychology (Fouad et al.,

2009). Such articulation allows for greater clarity in formulating training objectives and leads to more precise observations and targeted feedback, supporting supervisee development. Further, such an approach to competence informs every aspect of clinical training—the contents of the training rotation recruitment materials, criteria that are used in supervisee selection, method of evaluation, nature of feedback, competency-based learning processes, and associated activities. In addition, clear articulation of the competencies under training provides coherence in training and encourages transparency in supervision and training expectations.

## BENEFITS OF COMPETENCY-BASED CLINICAL SUPERVISION

Among its strengths, we (Falender & Shafranske, 2012b) identified six major areas that are enhanced through the use of the model.

- Competency-based clinical supervision supports the development of the supervisory working alliance by articulating training goals and learning objectives. Supervisor and supervisee are more likely to be on the same page, minimizing confusion about the goals and tasks and enhancing their collaboration, which will contribute to establishing an effective working relationship.
- Competency-based clinical supervision supports the development of competence by identifying specific knowledge, skills, and attitudes and values required to form the competence. This orients the supervisor's observations and helps the supervisee to focus self-assessment and metacompetence on the competency in development.
- Competency-based clinical supervision supports formative and cumulative assessment by articulating the knowledge, skills, and attitudes that make up the competencies that are the focus of training. Such an approach minimizes confusion, eliminates final evaluation "surprises," and sets the supervisory agenda.
- Competency-based clinical supervision supports learning by identifying with specificity the areas for improvement. Supervisees are given useful feedback to orient experiential and other forms of learning.

Assessment, feedback, evaluation, and learning are clearly linked, and competence develops—which is encouraging for the supervisee and supervisor and further reinforces collaboration in the relationship.

- Competency-based clinical supervision supports an understanding of competence as a lifelong process and encourages career-long learning in which expertise continues to develop, which we assume enhances not only effectiveness but also satisfaction.
- Each of the aforementioned points, if faithfully implemented, supports the development of competence, and in so doing not only supports professional development but also ensures client welfare. Clients are well-served when supervisees, who are providing for their treatment under supervision, are oriented to always think in terms of the competencies that are required to provide the highest quality of care and supervisors are oriented to identify the knowledge, skills and attitudes, and values that must be demonstrated to support the client's welfare.

These predicted outcomes and benefits are logical and internally consistent with the procedures used and fit with our personal experiences in conducting supervision; however, further empirical research is needed to establish firmly the effectiveness of the approach.

## HOW WE CAME TO A COMPETENCY-BASED MODEL OF CLINICAL SUPERVISION

Each of us was trained in an era in which little formal consideration was given to clinical supervision as a unique competence and, like our peers, we embarked on our supervisory journeys well-intentioned and drawing on appreciation of supervision as a learning process in which relationship played a central role, though we had no specific training. We individually cobbled together styles of supervision, focusing on enhancing supervisee self-awareness (what today we refer to as *metacompetence*) and incorporating a scientific attitude, focusing on the effectiveness of interventions. There were, of course, differences in our education and training experiences that influenced each of our approaches as well as the settings in which our professional lives took form.

I (Carol Falender) directed American Psychological Association–accredited internship programs at child and family community clinics for over 20 years (1978–2000). During the process, I assisted in and then wrote self-studies for accreditation. Throughout this experience, I viewed clinical supervision, a cornerstone of supervisee learning, professionalism, and development, as a sadly neglected aspect of clinical training. I trained practicum students, interns, and postdoctoral students in psychology. After I left the directorship role, I began focusing more intensely on clinical supervision, and with the support of my colleagues and friends at the California Psychological Association and Division II, Education and Training, of that association, I began organizing and conducting workshops on clinical supervision. I was influenced initially by the advanced scholarship in counseling psychology and, specifically, by Bernard and Goodyear (1998). Because my background was in child, adolescent, and family work, as well as clinical settings, I heard Paul Nelson speak of competency-based training and believed it was a missing link in supervision. I had worked with a highly diverse clinical population, across community and health center settings and was seeking a more applicable supervision model. I began to construct a framework related to competency-based supervision, drawing on my experience and the study and effort from self-studies for accreditation. I was fortunate to meet Edward Shafranske at this time through our work in the California Psychological Association and to collaborate with him on a workshop. He shared my passion for clinical supervision; he brought a wealth of knowledge, skills, attitudes, and perspective, and he proposed we write a book together. Our collaboration began in 2001 and has continued to the present. We were fortunate to be delegates to the Competencies Conference, and I was also a delegate to the Competencies Benchmarks Task Force, and through these, refined my thinking and learning through my association with incredible colleagues (Drs. Nadine Kaslow, Robert Hatcher, and Nadya Fouad, among others).

My (Edward Shafranske's) experiences as a faculty member (1988–present), director of clinical training (1995–1998), and PsyD program director (1998–present) at Pepperdine University strongly influenced my views on the importance of taking an explicit approach to competency-based

graduate education and clinical training. In each of these roles, I was faced with the challenges inherent in translating academic learning experiences to professional competencies as well as in documenting student learning (for institutional review and accreditation self-studies). I came to integrate more completely experiential learning in the classroom (to complement lectures on clinical knowledge, theory, and research) and focused increased attention on knowledge in supervision (to complement reflective practice and skill development). Values were always an area of interest, and throughout my career I dedicated considerable time and scholarship to examining the interface of religion and spirituality in psychological treatment (for example, Shafranske, 1996, 2013, 2014). Although not identical to those interests, the role of attitudes and, more important, values in professional practice finds expression in our model of clinical supervision. In our view, values influenced by multiple cultural contexts and loyalties form important dispositions affecting professional commitment and practice as well as personal satisfaction. I find that the competency-based model is particularly useful in such specialized training. Finally, the opportunity to supervise a diversity of trainees, including first-year doctoral students, psychiatric residents, and highly experienced clinicians (in psychoanalytic training) reinforces the importance of carefully identifying and assessing competencies and facilitating collaborative processes, particularly with respect to the goals and means to achieve the goals of supervision.

Our collaboration initially took root in our mutual involvement in the California Psychology Association's Division II, Education and Training, which brought together leaders and practitioners from academic and clinical training institutions. Through presentations, conferences, and collaborative efforts, this organization fostered a commitment to ensure the highest quality of training throughout the state. A natural synergy emerged between us based on our shared commitment to the profession, to the principles of science-informed practice, and concern for the next generation of psychologists. Our approach to competency-based clinical supervision has also been informed by the contributions of many col-

leagues and leaders, such as Dr. Nadine Kaslow, who have inspired our efforts to advance professionalism and to prepare psychologists (and other health service professionals) to meet the clinical needs of clients and the community.

## AN OVERVIEW OF THE CONTENTS OF THIS BOOK

The book is organized into two major sections: Foundations of Competency-Based Clinical Supervision, which presents the essential principles of the approach, and Core Competencies and Applications in Supervision, which highlights areas of specific supervisory focus. In Part I, Chapter 1 presents the groundwork and rationale for the model. In Chapter 2, we provide a blueprint for practice, describing each of the elements of competency-based clinical supervision and recommending best practices. In Chapter 3, we present an illustration of the approach through discussion of excerpts from a transcribed supervision session. In Part II, we focus attention on topics that are particularly salient to the conduct of clinical supervision, including diversity and multiculturalism (Chapter 4); personal factors (Chapter 5); legal, ethical, and regulatory competence (Chapter 6); supervisees who do not meet professional competence standards (Chapter 7); supervisor training and development (Chapter 8); and we close with a discussion of transforming supervision (Chapter 9).

## IMPLEMENTING COMPETENCY-BASED CLINICAL SUPERVISION

Implementing competency-based clinical supervision entails commitment and, consistent with the approach, requires specific knowledge, skills, and attitudes and values in its performance. Although this volume can furnish knowledge and present practical approaches to enhance supervision skills, the impetus to implement competency-based clinical supervision rests ultimately on your (our readers') attitudes, values-based commitments, and motivation. The commitment to be a competent and

effective supervisor, to provide the highest quality of supervision, to transform supervision when necessary, to stretch one's abilities, or simply to become better informed about contemporary developments in clinical training and supervision attest to professionalism and the principles that animate our profession.